

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED SEP 24 1962

-62-034307

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 116 Primary Registration District No. 3120 Registrar's No. 196

VS 300
Rev. 4/59

10365

20365

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington</u>		c. CITY OR TOWN <u>Washington</u>	
Length of stay in lb <u>44 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>609 S. Elm St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Herman</u> Last <u>Windmoeller</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance Co. Okawville, Ill.</u>	11. BIRTHPLACE (City and state or country) <u>U. S. A</u>
13a. FATHER'S NAME <u>Karl Windmoeller</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Zastrow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or no, unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Carrie Windmoeller, Washington, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>Chronic bronchitis & emphysema</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Symptomatic Leukemia</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>1956</u> to <u>Sept 19, 1962</u> and last saw him alive on <u>Sept 19, 1962</u> Death occurred at <u>10:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John B. Ryan</u>		22b. ADDRESS <u>Washington, Mo.</u>	
22c. DATE SIGNED <u>9-19-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Sept 24, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		25. DATE RECD BY LOCAL REG. <u>9/20/62</u>	
26. REGISTRAR'S SIGNATURE <u>L. H. C. H. H. H.</u>		27. FUNERAL DIRECTOR <u>W. H. H. H.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

NOV 1 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Lester A. Vitt

Licensed Embalmer No.

3254

P. O. Address

Washington, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.